DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

August 16, 2010

Max Long, Administrator
Walter Knox Memorial Hospital
1201 East Locust Street
Emmett, ID 83617

CCN: 13-1318 **Re: Complaint Control #: 4586 (EMTALA)**

Dear Mr. Long:

On August 6, 2010, an EMTALA revisit survey was conducted at your hospital, by the Idaho Bureau of Facility Standards (State survey agency) based on an allegation of compliance with the requirements of 42 Code of Federal Regulations (CFR) § 489.24 Responsibilities of Medicare Participating Hospitals in Emergency Cases and /or the related requirements at 42 CFR § 489.20.

After a careful review of the findings, we have determined that your hospital is now in compliance with these requirements. The proposed termination action from our April 26, 2010, letter is rescinded. We are closing the termination action and this case.

We thank you for your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program. If you have questions regarding this letter, please contact Kate Mitchell of my staff at (206) 615-2432.

Sincerely,

Steven Chickering
Western Consortium Survey and Certification Officer
Division of Survey and Certification

cc: Idaho Bureau of Facility Standards

COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSDM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

August 17, 2010

Max Long, Administrator
Walter Knox Memorial Hospital
1202 East Locust Street
Emmett, ID 83617

RE: Walter Knox Memorial Hospital, Provider #131318

Dear Mr. Long:

On August 6, 2010, a follow-up visit of your facility, Walter Knox Memorial Hospital, was conducted to verify corrections of deficiencies noted during the survey of March 31, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the Hospital into compliance, and that the Hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **August 30, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to the surveyors during their visit. If we can be of any help to you, please call us at (208) 334-6626.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/sp
Enclosures
ec: Kate Mitchell, CMS Region X Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131318	A. BUILDING _____ B. WING _____	R-C 08/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTER KNOX MEMORIAL HOSPITAL	1202 EAST LOCUST STREET EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{C 000}	INITIAL COMMENTS The following deficiencies were cited during the Medicare follow up EMTALA survey of your Critical Access Hospital and the Swing bed unit. Surveyors conducting the follow-up survey were: Patrick Hendrickson, RN, HFS, Team Leader Gary Banister, RN, HFS Acronyms used in this report include: CAH = Critical Access Hospital CNO = Chief Nursing Officer ED = Emergency Department EMTALA = Emergency Medical Treatment and Active Labor Act mcg = Micro Grams mg = Milligrams	{C 000}	RECEIVED SEP 0 1 2010 FACILITY STANDARDS C 302 All documentation, orders and accompanying forms will be completed in a thorough and accurate manner by all medical and nursing staff. These expectations have been reviewed at the Nursing staff meeting held on August 11, 2010 and will be discussed at the Medical staff meeting scheduled to be held on September 14, 2010 by Diane Wood, RN, CNO. In addition, Diane Wood will individually communicate to each nursing staff member who works in the ER, the items that were noted to be incomplete. These actions will be completed by September 30, 2010.	
C 302	485.638(a)(2) RECORDS SYSTEMS The records are legible, complete, accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based on staff interview, review of medical records and hospital policies, it was determined the CAH failed to ensure ED records were complete and/or accurate for 8 of 20 patients (#2, #3, #9, #10, #12, #13, #14, and #18) whose records were reviewed. This resulted in incomplete and/or inaccurate medical records and had the potential to interfere with clarity of information and accuracy of medication administration. Findings include: 1. Patient #9 was a 57 year-old-female who was admitted to the ED on 7/10/10 after she was	C 302		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Max Long | CEO | 8-30-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 302	Continued From page 1 found unresponsive at home. Nursing notes, dated 7/10/10, documented Patient #9 received the following medications: 8:13 AM, Narcan 0.4 mg 8:20 AM, Narcan 0.4 mg 8:28 AM, Romazicon 0.2 mg 8:32 AM, Romazicon 0.2 mg 8:42 AM, Romazicon 0.2 mg 9:38 AM, Narcan 2 mg However, the physician's "EMERGENCY ROOM NOTE," dated 7/10/10 that was not timed, stated Patient #9 received "Narcan x (times) 2, 2 mg a piece ..." This was not consistent with the nursing notes. Patient #9's "PHYSICIAN'S ORDERS," dated 7/10/10 that was not timed, indicated an order for "NARCAN" twice. The orders did not include the dose or the route of the medication. Additionally, the orders also stated "Romazicon 0.2 mg x 2." The order did not indicate the route of the medication. The CAH's CNO reviewed Patient #9's record on 8/05/10 starting at 1:13 PM. She confirmed the nurse gave Narcan 0.4 mg twice and 2 mg once, without complete physician's orders. She also confirmed the physician's note did not match the nurse's note. In addition, she also confirmed the physician's Romazicon order was incomplete, and the nurse gave an extra dose of the medication that was not ordered.	C 302	An audit process of the ER records will be developed by the Medical Records Manager, Joanna Phillips to insure the completeness of documentation and of the forms required for patients transferring to another facility. This will be completed by September 30, 2010 with the audit process to begin on October 1, 2010 and be reported quarterly to the Quality Improvement committee Supporting Documentation: Medical Staff Bylaws section 13.1.1 Admission and Discharge of Patients 13.12 Medical Records WKMH Policy Patient Transfer to Another Facility Standards of Nursing Practice with Role Differentiation in the Emergency Room	

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C 302	Continued From page 2 2. Patient #10 was a 69 year-old-female who was admitted to the ED on 7/16/10 following a motor vehicle accident. Nursing notes, dated 7/16/10, documented Patient #10 received the following medications: 9:31 AM, Zofran 4 mg 9:33 AM, Fentanyl 50 mcg 9:40 AM, Fentanyl 50 mcg 10:05 AM, Fentanyl 100 mcg Patient #10's record did not contain physician's orders for the above medications. This was confirmed with the CAH's CNO on 8/05/10 starting at 1:09 PM. 3. Patient #18 was a 41 year-old-female who was admitted to the ED on 7/26/10 with a complaint of chest pain. Nursing notes dated 7/26/10 at 1:25 PM, documented Patient #18 was given a nitroglycerine drip at 10 mcg per minute. Nitroglycerine is a medication used to manage chest pain. Patient #18's record did not contain a physician's order for the nitroglycerine drip. This was confirmed with the CAH's CNO on 8/05/10 starting at 1:05 PM. 4. Patient #13 was a 64 year-old-female who was admitted to the ED on 7/19/10 with symptoms of a stroke. Patient #13 was transferred to a secondary hospital for further treatment on 7/19/10 at 1:30 PM, as documented in the nursing notes. However, Patient #13's record did not contain an EMTALA Transfer Consent. This was confirmed with the CAH's CNO on 8/05/10	C 302		

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C 302	Continued From page 3 starting at 12:57 PM. 5. Patient #2 was an 8 year-old-male admitted to the ED on 5/22/10 at 11:38 AM, after being thrown from a horse. Patient #2 was transferred to a secondary hospital for further treatment on 5/22/10 at 12:55 PM, as documented in the nursing notes. The CAH's EMTALA Transfer Consent form was signed by Patient #2's parent. However, there was no documentation of a witness on the EMTALA Transfer Consent form. The EMTALA Transfer Consent form was incomplete. This was confirmed with the CAH's CNO on 8/05/10 starting at 1:15 PM. The absence of a witness on the CAH's EMTALA Transfer Consent form calls into question whether or not the patient/representative was truly informed of their EMTALA transfer rights. 6. Patient #3 was an 82 year-old-female admitted to the ED on 5/26/10 at 4:39 AM, when she experienced chest pain. Patient #3 was transferred to a secondary hospital for further treatment on 5/26/10 at 7:30 AM, as documented in the nursing notes. Patient #3's Physician Certification, dated 5/26/10 but not timed, lacked documentation of the name of the receiving facility and the receiving physician. Patient #3's nursing notes documented the name of the receiving hospital but not who would be the receiving physician. This was confirmed with the CAH's CNO on 8/05/10 starting at 1:17 PM. 7. Patient #12 was a 39 year-old-female admitted	C 302		

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C 302	Continued From page 4 to the ED on 7/16/10 at 6:00 PM, for suicidal ideation. Patient #12 was transferred to a secondary hospital for further treatment on 7/16/10 at 7:55 PM, as documented in the nursing notes. Patient #12's Physician Certification signed and dated, 7/16/10 at 7:30 PM, lacked documentation of a receiving physician. This was confirmed by the CAH's CNO on 8/05/10 starting at 1:20 PM. 8. Patient #14 was a 26 year-old-male admitted to the ED on 7/19/10 at 6:43 PM, for abdominal pains. Patient #14 was transferred to a secondary hospital for further treatment on 7/19/10 at 9:00 PM, as documented in the nursing notes. Patient #14's nursing notes contained documentation that he was transferred to the other hospital; however, his record did not contain an EMTALA Transfer Consent form. This was confirmed with the CAH's CNO on 8/05/10 starting at 1:30 PM. Missing and incorrect information from patient records had the potential to affect patient care.	C 302		

the bylaws and the rules and regulations, the bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff rules and regulations.

13.1.1 ADMISSION AND DISCHARGE OF PATIENTS Amended June 5, 2001 March 1, 2010

(a) The Hospital shall accept patients for care and treatment, except those patients requiring ongoing care beyond the capability of the Hospital and the capacity of its Medical Staff.

(b) A patient may be admitted to the Hospital only by a member of the Medical Staff. All Practitioners shall be governed by the official admitting policy of the Hospital.

(c) A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, the prompt completeness and accuracy of the medical record, necessary special instructions and the transmission of reports of the patient's condition. When these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

(d) Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admitting has been stated. In an emergency, such statement shall be recorded as soon as possible.

(e) A patient to be admitted on an emergency basis, who does not have a private Practitioner, will be assigned to a member of the Active Medical Staff.

(f) Each Practitioner must assume timely adequate professional care for his patients in the Hospital by being available, or having available an eligible alternative Practitioner with whom prior arrangements have been made. Each member of the staff who does not reside in the immediate vicinity shall name a member of the Medical Staff who is resident in the area and who may be called to attend the staff member's patients in an emergency or until the staff member arrives. In case of failure to name such associate, the Chief Executive Officer or Chief of Staff shall bave authority to call any members of the Active Staff.

(g) The admitting Practitioner shall be held responsible for giving information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others when the patient might be a source of danger.

(h) If a patient is known or suspected to be suicidal and transfer is not possible, the patient may be admitted to a general area of the Hospital and, as a temporary measure, restrained. Special nursing companionship also may be provided. Inasmuch as the potentially suicidal patient need psychiatric care and

treatment of a more sophisticated nature then available in the Hospital, the patient will be admitted as soon as possible to another hospital where suitable facilities are available.

(i) Patients shall be discharged only on an order of the attending Practitioner. Should a patient leave the Hospital against the advice of the attending Practitioner or without proper discharge, a notation of the incident shall be made in the patient's medical record.

(j) In the event of a Hospital death, the deceased shall be pronounced dead by the attending Practitioner or his designee within a reasonable time. The body shall not be released until an entry has been made in the appropriate records. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease, where the patient's course has been documented adequately within a few hours of death.

(k) It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent that is signed in accordance with state law. All autopsies shall be performed by a pathologist.

(l) The responsible practitioner shall have a face to face examination, in the emergency department, of every patient who has been classified as unstable/urgent by the RN conducting the Medical Screening Examination.

(m) The medical staff shall follow the provisions of the Emergency Medical Treatment Active Labor Act (EMTALA).

(n) A member of the Medical Staff shall be required to see an emergent patient in the emergency room within thirty (30) minutes after the emergency medical screen is completed. An emergent patient is defined as one who has an emergency medical condition.

13.1.2 MEDICAL RECORDS

(a) The attending Practitioner shall be responsible for the preparation of a complete and legible medical record of each patient. Its contents shall be pertinent and current. If possible or feasible, this record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory and radiology services, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress note, final diagnosis, condition on discharge, summary or discharge note (clinical resume) and autopsy report when performed.

(b) A complete admission history and physical examination shall be recorded within 24 hours of admission. This report should include all pertinent findings from an assessment of all the systems of the body. If a complete history

has been recorded and a physical examination performed prior to the patient's admission to the Hospital, a reasonable durable, legible copy of these reports may be used in the patient's Hospital record in lieu of the admission history and report of the physical examination, if the reports prior to admission were recorded by a member of the Medical Staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical finding must be recorded.

© When the history and physical are not recorded before an operation or a potentially hazardous diagnostic procedure, the operation or procedure shall be canceled, unless the attending Practitioner states in writing that delay would be detrimental to the patient.

(d) The attending physician shall countersign (authenticate) the history, physical examination and pre-operative note when they have been recorded by a member of the house staff.

(e) Pertinent progress notes, sufficient to permit continuity of care and transferability, shall be recorded at the time of observation. Whenever possible, each of the patient's clinical problems should be identified clearly in the progress notes and correlated with specific orders and test and treatment results. Progress notes shall be written at least daily on critically ill patients and patients where there is difficulty in diagnosis or management of the clinical problem.

(f) Operative reports shall include a detailed account of surgery findings and details of the surgical technique. Operative report shall be written (or dictated) within 24 hours following surgery for out-patients and in-patients. The reports must be signed promptly by the surgeon and made a part of the patient's current medical record.

(g) The consultant's opinions and recommendations contained in his report shall be evidence of a consultation and review of the patient's record. This report shall be made a part of the patient's record.

(h) The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending Practitioner's office record transferred to the Hospital before admission.

(i) All clinical entries in the patient's medical record shall be dated and authenticated accurately.

(l) A discharge summary (clinical resume) shall be written or dictated on all medical records of patients hospitalized more than 48 hours, except patients with normal obstetrical deliveries, normal newborn infants and certain selected patients with problems of a minor nature. These latter exceptions shall be identified by the Executive Committee of the Medical Staff and a final summation-type progress note shall be sufficient. In all instances, the content of the medical

record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible Practitioner.

(k) Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
(l) Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Hospital an otherwise shall not be taken away without permission of the Chief Executive Officer. For purposes of timely records update, a portion of the record may be sent out to the attending physician for completion in accordance with hospital policy. In case of a patient's readmission, all previous records shall be available for the use of the attending Practitioner. This shall apply whether the patient is attended by the same Practitioner or by another. A Practitioner's unauthorized removal of charts from the Hospital is grounds for suspension of the Practitioner for a period to be determined by the Executive Committee.

(m) Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research, provided confidentiality of personal information concerning the individual patients is preserved. The Chief Executive Officer shall approve access to medical records for research and study conducted by former members of the Medical Staff. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients in the Hospital.

(n) A medical record shall not be filed permanently until it is completed by the responsible Practitioner or is ordered filed by the Executive Committee.

(o) A Practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, and signed by the Practitioner.

(p) The patient's medical record shall be complete at the time of discharge, including progress notes, final diagnosis and (dictated) clinical resume. If this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's chart will be available in a designated place for five (5) days after discharge. If the record remains incomplete ten (10) days after all essential reports have been received and placed on the record, the Chief Executive Officer may notify the Practitioner by certified mail, return receipt requested, that his privileges to admit patients shall be suspended for five (5) days from the date of notice and shall be suspended beyond five (5) days until the records have been completed. The admitting office shall be notified of this action. Three such suspensions of admitting privileges within any 12 month period shall be sufficient causes for the Practitioner's permanent suspension of the privileges of the Hospital.

13.1.3 GENERAL CONDUCT OF CARE Amended June 5, 2001

(a) A general consent form signed by or on behalf of every patient admitted to the Hospital must be obtained at the time of admission. The admitting officer should notify the attending Practitioner if consent has not been obtained. When notified, the Practitioner shall be obligated to obtain proper consent before the patient is treated in the Hospital, except in emergency situations. In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature of and risks inherent in any special treatment or surgical procedure shall be obtained.

(b) All orders for treatment shall be in writing. A verbal order shall be considered to be in writing if dictated to a duly authorized person functioning within their sphere of competence and signed by the responsible Practitioner or appropriate member of the house staff.

(c) All orders dictated over the telephone shall be signed by the appropriately authorized person to whom dictated, with the name of the Practitioner per his or her own name. The responsible Practitioner shall autheuticate the orders next visit to the Hospital. Failure to do so shall be brought to the attention of the Executive Committee for appropriate action. Only RN's, LPN's and other licensed personnel may be authorized to accept verbal orders.

(d) The Practitioner's orders must be written clearly, legibly and completely.Orders that are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

(e) All previous orders are cancelled when patients go to surgery.

(f) All drugs and medications administered to patients shall be those listed the latest edition of the United States Pharmedcopoeia. Drugs brought into the Hospital by a patient should be held by the Hospital in safe-keeping until the patient's discharge to avoid inappropriate self-medication that might interfere with a course of treatment. All drug orders for narcotics, sedative, hypnotic, steroids, tranquilizers and antibiotics (administered orally or parenterally) shall be discontinued automatically as stated in the Automatic Stop Order Policy as approved by the Medical Staff.

(g) Any qualified Practitioner primarily is responsible for requesting consultation when necessary and calling in a qualified consultant.

(h) The attending Practitioner primarily is responsible for requesting consultation when necessary and calling in a qualified consultant.

(i) If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, she shall call this to the attention of her superior, who then may refer the matter to the Director of Nursing Services. If warranted, the Director of Nursing

Walter Knox Memorial Hospital		Department: General Nursing/ Emergency Room
Policy Title: PATIENT TRANSFER TO ANOTHER FACILITY		
Original Policy Date: July 15, 1998 **Effective Date:** May 22, 2001	**Approval Signature:** **Approval Date:** May 22, 2001	**Revision Date:** April 6, 2001

I. POLICY STATEMENT:

1. A physician is responsible for all emergency department care.

2. All persons who present at the emergency department with a request for examination or treatment will receive an appropriate medical screening examination reasonably calculated to determine whether an emergency medial condition exists. If an emergency medical condition exists, the patient will receive stabilizing treatment and/or an appropriate transfer to another facility as defined below.

3. No evaluation or treatment will be delayed while inquiries are made regarding financial arrangements. The medial screening examination and, if indicated, appropriate stabilizing treatment and/or transfer will be offered to all individuals regardless of diagnosis, race, color, national origin, handicap, or ability to pay.

4. The hospital will not penalize or take adverse action against a physician or qualified medical person who refuses to authorize the transfer of an individual with an emergency medical condition who has not been stabilized or against any employee because the employee reports a violation of the hospital's transfer policy.

II. PURPOSE:

This policy and procedure is established to facilitate the safe transfer of patients with emergency medical conditions and to ensure compliance with applicable laws and regulations, including but not limited to 42 U.S.C. SubSection 1395dd and its accompanying regulations.

"Transfer" means the movement (including discharge) of an individual outside a hospital's facilities at the direction of any person employed by or affiliated with the hospital. It does not include the movement of an individual who leaves the facility without the permission of the hospital. (*See* 42 C.F.R. Subsection 489.24(b)).

"Emergency medical condition" means: (1) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part; or (2) with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that the transfer may pose a threat to the health or safety of the woman or the unborn child. (*See* 42 C.F.R. SubSection 489.24(b)).

III. TRANSFERS AND DISCHARGES

A person who has an emergency medical condition may not be discharged or transferred to another facility unless one of the following occurs:

1. *The patient is stabilized.* The hospital may transfer the patient if the patient is "stabilized."

   - A patient is "stabilized" if no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. (*See* 42 C.F.R. SubSection 489.24 (b)).

   - With respect to a pregnant woman who is having contractions, the patient is "stabilized" if the woman has delivered the child and the placenta. (*See* 42 C.F.R. SubSection 489.24 (b)).

   - With respect to a patient with a psychiatric condition, the patient is "stabilized" if the patient is protected and prevented from injuring themselves or others. (*See* HCFA Interpretive Guidelines dated 5/98 at A407).

2. *Written informed consent is obtained.* If the patient is not "stabilized," the hospital may transfer the patient if the patient or a legally responsible person acting on the patient's behalf requests the transfer after being informed of the hospital's obligation to treat the patient and of the risks of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer. (See 42 C.F.R. SubSection 489.24 (d)(1)(ii)).

3. The physician or qualified medical person certifies that the benefits of transfer outweigh the risks. If the patient is not "stabilized," the hospital may transfer the patient if the physician or qualified medical person signs a written certification stating that, based upon the information available at the

time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the patient or, in the case of a woman in labor, to the woman or the unborn child. The certification must contain a summary of the risks and benefits. (*See* 42 C.F.R. Subsection 489.24 (d)(1)(ii)(B)).

- If a physician is present, the physician must sign the certification. (*See* 42 C.F.R. SubSection 489.24 (d)(1)(ii)(B)).

- If a physician is not present, a qualified medical person may sign the certification if he or she first consults with a physician and the physician agrees with the certification. The physician must subsequently countersign the certification. (*See* 42 C.F.R. 489.24 SubSection (d)(1)(ii)(C)).

IV. TRANSFER PROCEDURES

If the patient is not "stabilized," the hospital must comply with the following in transferring a patient:

1. *Obtain written informed consent or physician certification.* The hospital must obtain either (1) the written informed consent by the patient or his representative, or (2) the written certification by the physician or qualified medical person that the benefits of transfer outweigh the risks.

2. *Provide proper care during transfer.* The hospital must provide the medical treatment within its capacity to minimize the risks to the patient's health and, in the case of a woman in labor, the health of the unborn child. (See 42 C.F.R. SubSection (d)(2)(i)).

3. *Contact the receiving facility.* The hospital must contact the receiving facility and confirm (1) the receiving facility has available space and qualified personnel for the treatment of the patient; and (2) the receiving facility agrees to accept transfer of the individual and to provide appropriate medical treatment. In the "mental hold" context, transfers involve a number of issues: (See 42 C.F.R. SubSection (d)(2)(ii)).

4. *Send available patient records.* The hospital must send to the receiving facility all medical records (or copies thereof) related to the emergency medical condition that are available at the time of the transfer, including history, observations of signs and symptoms, preliminary diagnosis, diagnostic studies, treatment records, test results, informed consents. Any additional records (e.g., test results) must be sent as soon as they are available. (See 42 C.F.R. SubSection (d)(2)(iii)).

5. *Use proper means to effect the transfer.* The hospital must use qualified personnel and transportation equipment to effect the transfer, including the necessary and medically appropriate life support measures. (See 42 C.F.R. SubSection 489.24 at (d)(2)(iv)).

V. MEDICAL PROCEDURES: (if indicated per each individual situation)

1. Secure a patent airway.
2. Immobilize the vertebral column as indicated.
3. Ensure adequate breathing:
   a. Have a bag-valve mask available.
   b. Ensure there is an adequate supply of supplemental oxygen available in the transport vehicle.
   c. Assists with chest tube insertion prior to transport, as indicated, connect the chest tube to a chest drainage system.
   d. Attach a pulse oximeter.
4. Ensure additional intravenous fluids are available in the transport vehicle.
5. Insert indwelling urinary catheter and attach to a closed drainage system.
6. Insert a gastric tube as indicated.
7. Splint suspected fractures.
8. Cover wounds with sterile dressing.
9. Cover large burns with a dry sterile sheet/dressing.
10. Administer tetanus and antibiotic prophylaxis, as prescribed.
11. Administer analgesic and anti-anxiety medications, as prescribed.
12. Prepare copies (NEVER send originals) of medical records, results of diagnostic studies. When appropriate, copies of x-rays will be sent.
13. Obtain consent for transfer: After discussing the need for transfer with the patient and family, obtain consent for the transfer. Use clear and simple explanations to describe the need to transfer, as well as the risks.

14. Complete the transfer checklist.

15. Explain to the patient special circumstances surrounding the transfer, e.g., use of a helicopter.

16. The nurse will call the receiving facility and give a brief report.

17. Allow the family to see the patient.

18. Suggest that the family stay at the initial hospital until the patient has left.

19. Provide written direction to the receiving facility as needed. Caution the family NOT to attempt to follow the ambulance.

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Walter Knox Memorial Hospital		Department: Emergency Room
Policy Title: **STANDARDS OF NURSING PRACTICE with ROLE DIFFERENTIATION in the EMERGENCY ROOM**		
Original Policy Date: Unknown Effective Date: February 23, 2010	Approval Signature: Approval Date: February 23, 2010	Revision Date: February 2010

I. PURPOSE:

To outline the role of the professional nurse (RN), Licensed Practice Nurse (LPN), Certified Paramedic and other support staff in relationship to basic nursing practice in the Emergency Room.

II. SUPPORTIVE DATA:

Licensed nurses have individual accountability for the care of each patient within their scope of practice.

In the delivery of patient care, it is the role of the Registered Nurse (RN) to systematically apply knowledge and skill to the care, treatment, counsel, and health maintenance of individuals within the scope of their practice.

This includes:

Patient Assessment
Planning and evaluating patient care
Supervision of less-skilled patient care providers
Delegation of nursing acts, functions, or tasks

Other care providers assist the RN in the delivery of patient care within the boundaries of scope of practice, licensure, job description and Walter Knox Memorial Hospital Standards.

III. STANDARDS OF PRACTIVE:

I. Nursing Process:

The nursing process will be used in the delivery of patient care. This will include:

Assessment: Collection of assessment data that is consistent, continuous, and includes consideration of the patient and significant other. Assessment will include consideration of physical, psychosocial, spiritual, environmental, educational, self-care and discharge planning needs.

Planning: Analysis of assessment data in determining patient care problems and development of a plan of care and prescribing interventions which are based on current standards and research to attain goals (expected outcomes). This will be done in collaboration with the patient and their significant others, and the health care team.

Implementation: Initiation of nursing actions which provide for continuity of care and collaboration with other disciplines to achieve expected outcomes. Aspects of the plan of care may be delegated to members of the health care team to meet the identified priorities.

Evaluation: Ongoing evaluation of the patients' progress toward mutually agreed Upon goals and revisions to the plan as needed.

The RN or ER provider (physician or PA) will:

* Ensure ongoing collection of assessment data pertinent to the patient's identified problems and current health status.
* Review individual plans of care on an as needed basis and evaluate with the patient and interdisciplinary team.
* Revise the plan of care and/or expected outcomes as necessary to ensure progress towards desired outcomes.
* Ensure communication of the plan to members of the interdisciplinary team, the patient, and their significant others.

The LPN or Paramedic will:

* Collect data and implement intervention/measures as delegated by the RN.
* Document actions and observations in the patient record.
* Communicate data and observations to the RN.

IV. ASSIGNMENT PROCESS/DELEGATION:

Only a RN may delegate nursing acts, functions, or tasks. A RN may NOT delegate the following to a non-RN:

analyzing collected assessment data and formulating a nursing diagnosis
planning and evaluating patient care
accountability for assistant care providers
Medical Screening Examination

Competency validation of the delegatee is required before nursing acts, tasks, or functions are assigned/delegated.

The RN exercises informed judgment and uses the delegatee's validated competency and individual qualifications as criteria when delegating nursing activities.

The greater the complexity of care requirements and unpredictability of outcomes, the greater the RN involvement required in care.

V. PATIENT EDUCATION:

Education appropriate to the patient's abilities will be provided to patients and their significant others to ensure an understanding of their condition and treatment and ability to manage self-care as appropriate after discharge.

The RN or provider(physician or PA) will:

1) Assess the patient/family learning needs, including ability to learn and current understanding.
2) Develop a plan, including:
   expected outcomes
   content to be discussed
   instructional method: how, when, who, and timing
3) Implement or delegate teaching considering:
   complexity of information to be taught
   learning abilities of the patient and significant others
   competence/skills of the delegatee
4) Communicate and document the plan, including progress towards outcomes to the healthcare team, patient, and significant other.
   Evaluate the effectiveness of the plan and the achievement of outcomes and revise plan as needed.

The LPN or Paramedic will:

1) Implement elements of the teaching plan as delegated.
2) Communicate to the RN information taught and patient/family responses to teaching.
3) Reinforce information provided by other health team members.

VI. MEDICATION ADMINISTRATION

Administration of prescribed medication is one aspect of the patient's plan of care. Decisions related to the delegation of medication administration will be based upon an assessment of treatment and patient. Competency validation of the delegatee is required before medication administration is delegated.

Certain factors are considered to place the hospitalized patient at high risk for delegation of medication administration and require a qualified RN for administration:

ALL intravenous push medications

Chemotherapy Drug Administration (IV, PO, IM)
Vasoactive Drugs by Continuous Infusion
IV Pitocin
Insulin Continuous Infusion
Neuromuscular Blocking Agents
KCl and Mg replacement IV bolus
Hemodynamically unstable patients
Limited availability of RN/physicians to assess
High degree of clinical judgment required
Medications administered through central/PICC lines
TPN
TPA
IV antiarrhythmic

The RN will:

Assess the degree of risk involved with medication administration and the competency of the delegatee before delegating to LPN

Assess the patient's medication plan before delegating.

Assess the patient's response to medications and revise the plan as needed.

The LPN or Paramedic will:

Administer medications as delegated by the RN or ER provider.

Communicate to RN or ER provider the patient's response to medications.

In the event a medication or route of prescribed medication is found to be unsafe due to patient tolerance, nursing staff will notify physician for clarification and/or new orders

VII. DOCUMENTATION:

Accurate documentation of care provided and patient responses will be recorded in the medical record at the time care is provided.

All care providers will:

Document the care they provide and the patient's responses to that care.

In the event of electronic medical record malfunction (EMR), (i.e., time and date stamp error), handwritten corrections will be made to the printed record. If errors are noted in the EMR, a notation will be added in the nursing notes describing noted errors.

VIII. DISCHARGE PLANNING:

Discharge planning will be initiated as part of the admission process in collaboration with the patient/significant other and other health disciplines.

The RN or provider will:

Assess educational needs, functional status, adequacy of supports (psycho-social, financial, environmental) and anticipated alterations due to hospital stay.
Identify anticipate resource needs, plan of provision of needed support after discharge, and assure availability of resources at discharge.
Assure written instructions to patient/family regarding at-home function including:

activity
safe and effective use of medications
Drug/Food interactions and dietary instructions
sign/symptoms to monitor and when to seek medical attention
who to call if questions or concerns
disease process and treatment
incision/wound care
health care follow-up (community resources)
proper use of equipment
rehabilitation techniques

Document an evaluative summary of the patient's status related to expected outcomes at time of discharge.

The LPN or Paramedic will:

Implement elements of the teaching plan as delegated.
Communicate the RN information taught and patient/significant other responses to teaching.
Reinforce information provided by other health team members.

IX. REFERENCES:

Nurse Practice Act: Idaho State Board of Nursing, July, 1996
Guidelines for Delegation: Use of the Nursing Process, October, 1993. Michigan Nurses' Association Paper
"American Nurse's Association position Statement on registered Nurse Utilization of unlicensed Assistive Personnel," Februrary,1993. The American Nurse